BILL LOCKYER, Attorney General
of the State of California
VIVIEN H. HARA
Supervising Deputy Attorney General
CATHERINE E. SANTILLAN
Senior Legal Analyst
California Department of Justice
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5579
Facsimile: (415) 703-5480

Legal Representatives for Complainant

BEFORE THE
RESPIRATORY CARE BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: Tami L. Deschene 640 W. San Martin Avenue San Martin CA 95046 Respiratory Care Practitioner License no. 18837 Respondent.	Case No. R-1973 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Stephanie Nunez (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Respiratory Care Board of California, Department of Consumer Affairs.

2. On or about September 3, 1996, the Respiratory Care Board issued Respiratory Care Practitioner Number 18837 to Tami L. Deschene (Respondent). The Respiratory Care Practitioner license was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2005, unless renewed.

JURISDICTION

3. This Accusation is brought before the Respiratory Care Board (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are

to the Business and Professions Code unless otherwise indicated.

4. Section 3710 of the Code states: "The Respiratory Care Board of California, hereafter referred to as the board, shall enforce and administer this chapter [Chapter 8.3, the Respiratory Care Practice Act]."

5. Section 3718 of the Code states: "The board shall issue, deny, suspend, and revoke licenses to practice respiratory care as provided in this chapter."

6. Section 3750 of the Code states:

"The board may order the denial, suspension or revocation of, or the imposition of probationary conditions upon, a license issued under this chapter, for any of the following causes:

"(f) Negligence in his or her practice as a respiratory care practitioner.

"(g) Conviction of a violation of any of the provisions of this chapter or of any provision of Division 2 (commencing with Section 500), or violating, or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate any provision or term of this chapter or of any provision of Division 2 (commencing with Section 500).

"(k) Falsifying, or making grossly incorrect, grossly inconsistent, or unintelligible entries in any patient, hospital, or other record.

"(o) Incompetence in his or her practice as a respiratory care practitioner."

7. Section 3755 of the Code states:

"The board may take action against any respiratory care practitioner who is charged with unprofessional conduct in administering, or attempting to administer, direct or indirect respiratory care. Unprofessional conduct includes, but is not limited to, repeated acts of clearly administering directly or indirectly inappropriate or unsafe respiratory care procedures, protocols, therapeutic regimens, or diagnostic testing or monitoring techniques, and violation of any provision of Section 3750. The board may determine unprofessional conduct involving any and all aspects of respiratory care performed by anyone licensed as a respiratory care practitioner."

8. California Code of Regulations, title 16, section 1399.370, states:

"For the purposes of denial, suspension, or revocation of a license, a crime or act shall be considered to be substantially related to the qualifications, functions or duties of a respiratory care practitioner, if it evidences present or potential unfitness of a licensee to perform the functions authorized by his or her license or in a manner inconsistent with the public health, safety, or welfare. Such crimes or acts shall include but not be limited to those involving the following:

"(a) Violating or attempting to violate, directly or indirectly, or assisting or abetting the violation of or conspiring to violate any provision or term of the Act.

COST RECOVERY

9. Section 3753.5, subdivision (a) of the Code states:

"In any order issued in resolution of a disciplinary proceeding before the board, the board or the administrative law judge may direct any practitioner or applicant found to have committed a violation or violations of law to pay to the board a sum not to exceed the costs of the investigation and prosecution of the case."

10. Section 3753.7 of the Code states:

"For purposes of the Respiratory Care Practice Act, costs of prosecution shall include attorney general or other prosecuting attorney fees, expert witness fees, and other administrative, filing, and service fees."

11. Section 3753.1 of the Code states:

"(a) An administrative disciplinary decision imposing terms of probation may include, among other things, a requirement that the licensee-probationer pay the monetary costs associated with monitoring the probation. "

FIRST CAUSE FOR DISCIPLINE

(Negligence; Incompetence; Unprofessional conduct)

12. Respondent is subject to disciplinary action under section 3750(f) [negligence], 3750(g), 3750(o) [incompetence] and 3755 [unprofessional conduct] in that she acted negligently while providing care for a patient in the emergency room. The circumstances are

as follows:

13. On or about January 2, 2004, respondent was employed as a respiratory care practitioner (RCP) for Santa Clara Valley Medical Center in San Martin, California. On that date, she was the respiratory care practitioner assigned to the Emergency Department from 1500 (3:00 p.m.) until 2300 (11:00 p.m.). At approximately 5:30 p.m, there was a major trauma call in the Emergency Department. Patient A., a 48 year old male bicyclist, had been hit by an SUV. M.T., another respiratory care practitioner, heard the announcement and responded to the Emergency Department to help. She was the first RCP to arrive in the Emergency Department. M.T. learned from report that the patient would need to be placed on a ventilator to ensure adequate oxygenation and breathing. The ventilator in the Emergency Department trauma room is stored in an alcove at the back of the room. For proper operation, it must be connected to an electrical outlet and to compressed air and oxygen. There are no oxygen or compressed air outlets in the alcove. The alcove is seven to eight feet away from the head of the trauma bed. Therefore, the ventilator has to be moved out of the alcove area to the head of the trauma bed. M.T. began setting up the ventilator while it was in the alcove, and it was still in the alcove when respondent arrived in the room.

14. At 5:43 p.m., Patient A. arrived in the Emergency Department. Dr. J.S., the Trauma physician, requested that anyone who was not needed leave the room, so M.T. left. Patient A. was intubated and hand ventilated. His oxygen saturation values were in the high 90s, which was appropriate for a patient assisted in his ventilatory efforts.

15. Respondent placed Patient A. on the ventilator. The ventilator alarmed and kept alarming. Respondent adjusted the alarms. Dr. J.S. noted that the patient appeared to be struggling to get deeper breaths than the ventilator was delivering. Immediately after placing the patient on the ventilator, respondent noted that the patient's oxygen saturation dropped from the high 90s to the 80s. Respondent removed Patient A. from the ventilator and began hand ventilation. His oxygen saturation returned to the high 90s. Respondent then placed Patient A. back on the ventilator but did not listen to his breath sounds after doing so. Respondent then left the trauma room to deliver respiratory treatment to another patient. She did not notify the nurse

that she was leaving nor did she notify the trauma physician, in violation of hospital policy which requires a respiratory therapist to remain with a trauma patient until released from responsibility by the treating physician.

16. While respondent was gone, at 6:00 p.m., it was noted that Patient A. seemed to be fighting the ventilator. He was given medication to sedate him, and the nurse began to prepare him for CT scan. As the nurse plugged in the transport monitor, he noted that the patient's heart rate was in the low 20s. Patient A. then had a full cardiac arrest and cardiopulmonary resuscitation (CPR) was initiated. At this point, respondent returned to the room. After Patient A. was resuscitated, she placed him back on the ventilator, and the patient's oxygen saturation fell to 79%. She removed A. from the ventilator and hand ventilated him, and his oxygen saturation increased to 100%. Respondent again placed the patient back on the ventilator, which was alarming. The oxygen saturation monitor was malfunctioning so she adjusted the oxygen saturation probe and found it to be in the 80s. Patient A. was hand ventilated again; the saturation returned to 100%. One of the nursing personnel noted that Patient A.'s chest did not rise and fall with each ventilator breath, and shared that observation with respondent. At that point, she realized that the ventilator was not connected to the oxygen and compressed air outlets. She then connected the ventilator to the gas sources, placed Patient A. back on the ventilator and his oxygen saturation stabilized in the 90s.

17. Dr. J.S. informed respondent that Patient A. would be taken to the CT scanner and asked respondent to set up a ventilator in the scanner room. When Dr. J.S. and the nurse arrived in CT with Patient A., respondent was not there and had not set up the ventilator. Respondent was paged several times with no response. At 6:45 p.m., the CT scan was begun with Dr. J.S. hand ventilating Patient A. At 6:55 p.m., respondent was paged "RT Stat to CT-2." Respondent was taking a meal break at the time of the page.

18. Respondent's failure to properly set up the ventilator; the act of leaving Patient A., a critically ill patient, to treat other patients without notifying the physician in charge; and her failure to follow doctor's orders to set up the ventilator, demonstrates a departure from the standard of care, and is cause for discipline pursuant to code sections 3750(f) [negligence],

3750(g), 3750(o) [incompetence] and 3755 [unprofessional conduct.]

SECOND CAUSE FOR DISCIPLINE

(Grossly incorrect patient chart entries)

19. Respondent is subject to disciplinary action under section 3750(k) [making grossly incorrect, grossly inconsistent, or unintelligible entries in any patient, hospital or other record] in that she did not chart the correct time entries in the Ventilator Flow Sheet for Patient A. The circumstances are as follows:

20. On or about January 2, 2004, respondent charted the incorrect time in the Ventilator Flow Sheet for Patient A. She charted "1750" as the time of ventilator manipulation, then drew a line through that entry and wrote in "1550"; however, the patient had arrived at 1743 hours (5:43 p.m.). Respondent charted adjustments made to the ventilator at "1620" , which was an incorrect time entry, since the patient had arrived at 1743 hours.

21. Therefore, respondent's failure to correctly chart the time in the Ventilator Flow Sheet for Patient A. is a violation of code section 3750(k), and is cause for discipline.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Respiratory Care Board issue a decision:

1. Revoking or suspending Respiratory Care Practitioner Number 18837, issued to Tami L. Deschene.

2. Ordering Tami L. Deschene to pay the Respiratory Care Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring;

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3. Taking such other and further action as deemed necessary and proper.

DATED: March 29, 2005

Original signed by Liane Zimmerman for:
STEPHANIE NUNEZ
Executive Officer
Respiratory Care Board of California
Department of Consumer Affairs
State of California
Complainant